DR. JACQUELINE HONIG'S MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM IN SUPPORT OF HER MOTION FOR SUMMARY JUDGMENT

EXHIBIT D

Deposition of Darla Welker

STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS
COUNTY OF CHARLESTON 9TH JUDICIAL CIRCUIT
MICHELLE CHA HOLLIMAN, individually and as personal representative of the Estate of Allen B. Holliman,

Plaintiff,

vs. CASE NO. 2020-CP-10-2902

WE ARE SHARING HOPE SC, MEDICAL UNIVERSITY OF SOUTH CAROLINA, and UNITED NETWORK FOR ORGAN SHARING,
Defendants.

VIDEOCONFERENCE
DEPOSITION OF: DARLA A. WELKER

DATE: December 14, 2020

TIME: 10:04 a.m.

LOCATION: Mount Pleasant, South Carolina

TAKEN BY: Counsel for the Plaintiff

REPORTED BY: MARIE H. BRUEGGER, RPR, CRR
(Appearing Via VTC)

APPEARANCES OF COUNSEL:

ATTORNEYS FOR THE PLAINTIFF
MICHELLE CHA HOLLIMAN, individually and as personal representative of the Estate of Allen B. Holliman:

WYCHE, PA
BY: LUCY DINKINS (Via VTC)
BY: JOHN C. MOYLAN III (Via VTC)
807 Gervais Street, Suite 301
Columbia, SC 29201
(803)254-6542
ldinkins@wyche.com
jmoylan@wyche.com

ATTORNEYS FOR THE DEFENDANT
WE ARE SHARING HOPE SC:

HOOD LAW FIRM
BY: MOLLY H. CRAIG (Via VTC)
172 Meeting Street
Charleston, SC 29401
(843)577-4435
molly.craig@hoodlaw.com

ATTORNEYS FOR THE DEFENDANT
MEDICAL UNIVERSITY OF SOUTH CAROLINA:

BUYCK & SANDERS, LLC
BY: DARREN K. SANDERS (Via VTC)
305 Wingo Way
Mt. Pleasant, SC 29464
(843)377-1400
dks@buyckfirm.com

APPEARANCES CONTINUED:

ATTORNEYS FOR THE DEFENDANT
UNITED NETWORK FOR ORGAN SHARING:

HALL BOOTH SMITH, PC
BY: JACK G. GRESH (Via VTC)
BY: LAUREN SPEARS GRESH (Via VTC)
111 Coleman Boulevard, Suite 301
Mt. Pleasant, SC 29464
(843)720-3460
jgresh@hallboothsmith.com
lgresh@hallboothsmith.com

ALSO PRESENT:
Christe All (Via VTC)

I N D E X

	Page/Line
DARLA A. WELKER	
Examination by Ms. Dinkins	6 5
SIGNATURE OF DEPONENT	177 1
CERTIFICATE OF REPORTER	176

REQUESTED INFORMATION INDEX

(No Information Requested)

E X H I B I T S

		Page/Line
PLAINTIFF'S		
Exhibit 1	CAT ABO Verification Form [WASH 0229]	84 19
Exhibit 2	Serology and ABO Reporting [WASH 218]	88 25
Exhibit 3	ABO Reporting [WASH 322]	89 3
Exhibit 4	Transfusion/Infusion - Hemodilution Worksheet [WASH 94]	99 25
Exhibit 5	Case Notes [WASH 171-189]	104 20
Exhibit 6	Blood Bank Tests Data [WASH 216]	110 3

		Page/Line
Exhibit 7	Blood Bank Tests Data [WASH 217]	110 6
Exhibit 8	Call Notes [WASH 36-42]	116 9
Exhibit 9	Blood Product/Colloid Administration Summary [WASH 93]	123 5
Exhibit 10	Laboratory Results [WASH 300-307]	136 5
Exhibit 11	Transfusion/Infusion - Hemodilution Worksheet [WASH 96]	142 2
Exhibit 12	Photograph of Vial [MUSC RRFP 194]	144 14
Exhibit 13	DonorNet Documents [WASH 53, 54, 58, 91, 93, 94, 248-258, 262-265, MUSC_Subpoena 90-100]	150 23
Exhibit 14	Organ Supply List [WASH 116-117]	153 8
Exhibit 15	Text Messages [WASH 372-388]	160 23
Exhibit 16	Email Chain ending in a 12/4/18 Email to Stanton and DeStefano from Thomas [MUSC_Subpoena 14-15]	172 9

Q As an AOC, are you involved with determining and reporting the blood type of organ donors?

A Yes.

Q And can you describe your involvement with that, please?

A The blood type is, again, sent with VRL -- to VRL for two samples that are drawn at two different times, and we also run a hospital ABO in the beginning.

So when we receive the two VRL specimens, those are received by the clinical allocation technician. When those are received, they would then report them to the on-site clinician, and then they notify me as to the results of those two samples that were drawn. And then I verify that it's the correct donor with the correct UNOS ID, the correct birthdate, the correct collection time for both of those, and verify that those two ABOs match.

Q And you also mentioned running a hospital ABO?

A Correct.

Q Can you tell me a little bit about that, please?

A No. And there would have been -- at different times when the case starts, there are other clinicians on. Michael was on that particular day.

Q For the donor at issue in this case?

A Yes, for the donor the day that the blood type was typed as well as for the OR and the recovery in the OR.

Q So would it have been his role to review the medical records of the donor at issue in this case?

A Yes.

Q Are you responsible for approving the blood type reported for donors that you're working on?

A Yes.

Q And what do you do in order to approve a blood type reported for a donor?

A Again, I look at the two samples that are drawn at VRL to compare those two, and if they're the same blood type, then we would report those and verify those two ABOs as the reported case of what the -- that's the normal practice. So those two blood types match, they have the -- it's the right donor, the right -- the right VRL

form, requisition form drawn at two separate times, both the same result. Those are reported as the ABO.

Q And so what happens if those VRL results don't match?

A We utilize the hospital ABO. So our policy and practice is if we have an indeterminate ABO from VRL, our policy states or allows for us to use two different samples drawn at two different times.

And we had the initial ABO, and I don't remember the date and time, but I do recall that it was -- and then Michael and I spoke about ordering a second ABO when we got the indeterminate results on this particular case, and Michael -- while we were on the phone, Michael reported that he'd found another blood type that was drawn approximately 23 hours later, on a different date, and the result was the same, so we had two ABOs that were reported by the hospital as being O. And if we had two samples that reported at two different times, per UNOS policy and WASH policy, we were allowed to use those two samples.

Q And so you just were describing the blood typing results for the donor at issue in

massively transfused, we put in place a hard stop on the case, and that cannot be released until the medical director has reviewed all of the blood types and releases that blood type as being resulted as what they determine it to be with their investigation.

Q And when was that procedure put in place?

A Shortly after this event.

Q And it was put in place because of this event?

A Yes.

Q In November 2018, did the medical directors get involved in a donor who had had massive blood transfusions?

A I don't recall the extent, but again, that sample -- we had two samples drawn at two different times that were -- resulted the same by the hospital, and that was within WASH's policy as well as UNOS's policy, so we -- no, I don't recall that we did at that point just because we had two resulted samples that were the same.

Q So you're saying you don't recall that the medical directors became involved in this donor's case?

I'm assuming that it's kept in DonorNet somewhere who did the verifications.

Q Can you please describe what you do in general to approve a donor's blood type?

MS. CRAIG: Object to form, "approved."

THE WITNESS: So I'm supposed to answer that one, correct?

MS. CRAIG: Yes. And, Darla, you're supposed to answer all questions unless I specifically instruct you not to answer it.

THE WITNESS: Okay.

MS. CRAIG: Thank you.

THE WITNESS: In general practice, again, we receive serologies which contain -- and NATs which contain two different samples drawn for blood typing. They're drawn at two different times. So we verify that it's the same UNOS ID on both of those samples, that they're drawn at two different times, or collected at two different times is actually how it's stated on the form, and that it's the same requisition form, and that those two ABOs match.

BY MS. DINKINS:

Q And what did you do to approve this

donor's blood type?

MS. CRAIG: Object to form.

THE WITNESS: Those two results came back indeterminate. And when those two came back indeterminate, I first spoke with Janine, and then I called Michael or Michael called me, I'm not 100 percent certain, and we discussed drawing another blood type. And Michael informed me that he had a second ABO at the hospital that was drawn approximately 24 hours out from the first ABO that was drawn, and that they both resulted in an O. So we had two samples that were drawn at two different times that both resulted in an O, and so we followed our Sharing Hope policy as well as UNOS guidelines.

BY MS. DINKINS:

Q Did Michael tell you that the donor had received blood transfusions?

A I don't recall.

Q Did you ask him whether the donor had received any transfusions?

A I don't recall.

Q Why did you think that the VRL results came back indeterminate?

A Sometimes samples are hemodiluted

MS. CRAIG: Same objection.

THE WITNESS: This particular case, this ABO discrepancy.

BY MS. DINKINS:

Q And so is it your understanding that these procedures were put in place so that a situation like what happened with this donor would not happen again?

A Do you mean to prevent a situation? Yes.

Q In 2018, did WASH have a written protocol for addressing conflicting or indeterminate blood type results?

A No, just that we had to have two different blood types from two different draw times that resulted in the same blood type.

Q And there was no written policy about what to do if one of the blood type results came back indeterminate. Is that correct?

A If one blood type -- if the blood type came back discrepant, we were to look to draw another sample to have two samples to compare, but we found a second sample, again, which was almost 24 hours apart, same blood type, collected at the same hospital, that resulted the same.